

**STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220 OR 800-745-7371**

**APPLICATION FOR CERTIFICATION AS A PHYSICIAN ASSISTANT
INSTRUCTIONS AND CHECKLIST, PAGE ONE OF TWO**

Thank you for your interest in physician assistant (PA) certification in Vermont.
Enclosed please find the application for certification. If you require an application status update, please telephone the office. It takes a minimum of six weeks to complete the process if there is nothing in the application requiring further Board review.
Any applicant with a disability who needs an accommodation should contact the Board office.
The following is a list of documents required (Unless noted, a copy of the original, if applicable—is required to be submitted):

- 1) ☐ Fee of \$115 (non-refundable) Check made payable to Vermont to the Vermont Department of Health.
- 2) ☐ Completed APPLICATION FOR CERTIFICATION AS A PHYSICIAN ASSISTANT IN VERMONT.
- *3) ☐ Certified copy of Birth Certificate
- 4) ☐ Employment contract. We have enclosed an employment contract form.
- 5) ☐ PRIMARY SUPERVISING PHYSICIAN APPLICATION must be completed by your primary physician and returned directly to this office. The Board may invite the supervising physician to an interview if the Board has not previously reviewed the system of care delivery in which you propose to practice.
- 6) ☐ SECONDARY SUPERVISING PHYSICIAN APPLICATION from all secondary supervising physician(s).
- 7) ☐ VERIFICATION OF PHYSICIAN ASSISTANT LICENSURE OR CERTIFICATION must be completed by the Licensing Board of each state where you now or have ever practiced as a physician's assistant. Copies of certifications or licenses are not accepted.
- *8) ☐ For University trained applicants:
☐ A. A Certificate of Physician Assistant Education must be completed by your University.
☐ B. Proof of satisfactorily completing the certification examination given by NCCPA (National Commission on the Certification of Physician Assistants) from NCCPA. – To be sent directly to this office from the Examining Agency.
- 9) ☐ Scope of Practice (See attached definition): A detailed description of the duties and scope of practice delegated to you by your supervising physician including authority to prescribe medications.
- 10) ☐ Two (2) Completed Reference Forms mailed directly to the Board by the physician
- 11) ☐ Personal Interview Required: As soon as your application is complete and the review process is finished, you will be provided with the name, address and telephone number of the Medical Board member you are to contact for a personal interview. (The Primary Supervising Physician also is interviewed by phone if he or she has never supervised a PA in Vermont.)

*Note: FCVS Acceptance- The Board accepts certain documents (see * above) verified by the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS). For more information please call 1-888-ASK-FCVS.*

- 12) ____ Completed Form A if you answered yes to any question.
- 13) ____ Unemployment/Tax/Child Support form.
- 14) ____ Completed Form B
- 15) ____ National Practitioner Data Bank Self Query (NPDB)
- 16) ____ CV/Resume
- 17) ____ Statement of Good Standing
- 18) ____ Please read the enclosed Board Statute and Rules and adopted AMA and AAPA recommendations for the working relationship between physicians and physician assistants.

*Note: FCVS Acceptance- The Board accepts certain documents (see * above) verified by the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS). For more information please call 1-888-ASK-FCVS.*

P.O. Box 70, Burlington, VT 05402
802-657-4220 or 800-745-7371

I hereby apply for CERTIFICATION AS A PHYSICIAN ASSISTANT in the state of Vermont

1. Name: _____
(Last) (First) (Middle)

2. Home Address: _____
(Street)

(City) (State) (Zip)

3. Work Address: _____
(Street)

(City) (State) (Zip)

4. Please check your preferred mailing address: ☐ Home ☐ Work

5. Have you ever legally changed your name? ____Yes ____ No If yes, enclose a certified copy of the document by which the name was changed.

6. Your name, as it should appear on your certificate: _____

7. Have you ever been licensed or certified in Vermont or elsewhere under another name? ____ yes ____ no
If yes, please complete the following.

[illegible]

8. Home Telephone Number: () _____

9. Work Telephone Number: () _____

10. E-mail address: _____

11. Date of Birth: Month: _____ Day _____ Year _____

12. Place of Birth: _____
Attach a certified copy of your birth certificate.

13. Were you in active clinical practice in the past 12 months? _____ Yes No

14. Certification Examination Taken – (Check the appropriate box and enter the date of examination):

___ (___/___/___) University Trained --NCCPA Examination

___ (___/___/___) Vermont Apprenticeship Trained

Education

15. List schools attended:

(Name and Location of Institution)	(From Month/Year to Month/Year)	(Degree)
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(Name and Location of Institution)	(From Month/Year to Month/Year)	(Degree)
------------------------------------	---------------------------------	----------

(Name and Location of Institution)	(From Month/Year to Month/Year)	(Degree)
------------------------------------	---------------------------------	----------

Supervising Physicians

16. List name and specialty of Primary Supervising Physician

17. List name and specialty of Secondary Supervising Physician(s):

Other Licenses and Certifications

18. Do you hold, or have you ever held, a license or certification as a medical practitioner in Vermont or any other state?

___ Yes ___ No

If yes, complete the section below. Your application is not complete until we receive a Verification of Licensure or Certification from the licensing or certification authority in each case.

State	Certificate/License Number	Type of License/Certification	Date Issued	Status (Active or Inactive)
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19. Are you a graduate of a program accredited by the Committee on Allied Health Education and Accreditation (CAHEA) or its successor agency? _____ Yes _____ No

20. Do you hold a National Commission for the Certification of Physician Assistants (NCCPA) Certificate? _____ Yes _____ No If yes, attach a copy.

NCCPA Certificate Number: _____ Expiration date: _____

21. When are you scheduled to begin work in Vermont?: _____

Training

22. List chronologically all formal medical training programs. Give program names, addresses, exact dates (month, day, year) and type of training. Include COPIES OF CERTIFICATES.

Program Name	Address	From/To	Training
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List any other significant training:

24. Do you have now or have you previously had hospital privileges? _____ Yes _____ No

25. List all hospitals where you have, or previously have had, privileges:

NAME	ADDRESS	FROM/TO
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26. What has been your physical residence(s) (city/state) in the past ten years? _____

Part II

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

27. Have you ever applied for and been denied a license or certificate to practice medicine or any other healing art?

Vermont Department of Health, Board of Medical Practice

Physician Assistant Initial Application

Revised 6/1/10

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_____Yes _____No

28. Have you ever withdrawn an application for a license or certificate to practice medicine or any other healing art?

_____Yes _____No

29. Have you ever voluntarily surrendered or resigned a license or certificate to practice medicine or any other healing art in lieu of disciplinary action or any other reason?

_____Yes _____No

30. Are any formal disciplinary charges pending or has any disciplinary action ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

_____Yes _____No

31. Have you ever been denied the privilege of taking an examination before any state medical examining board?

_____Yes _____No

32. Have you ever discontinued your education, training, or practice for a period of more than three months?

_____Yes _____No

33. Have you ever been dismissed or suspended from, or asked to leave a training program before completion?

_____Yes _____No

34. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, reduced, suspended or revoked, or resigned from a medical staff after a complaint or peer review action was initiated against you?

_____Yes _____No

35. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or restricted by, or surrendered to any jurisdiction or federal agency at any time?

_____Yes _____No

36. Are you presently or have you ever been a defendant in a criminal proceeding?

_____Yes _____No

37. Do you currently or have you ever prescribed any prescription medication over the internet? This does not include prescribing you would do using electronic medical records in your practice.

_____Yes _____No

Confidential Section (The following section is exempt from public disclosure)

Any "yes" response to the questions below must be fully explained on the enclosed Form A.

38. To your knowledge, are you the subject of an investigation by any other licensing or certification board under which you have not been charged as of the date of this application?

_____ Yes _____ No

39. To your knowledge, are you presently the subject of criminal investigation under which you have not been charged?

_____ Yes _____ No

MEDICAL QUESTIONS

Please answer "Yes" or "No" to the questions below. Definitions are provided to assist you in answering. Please explain any "Yes" answers on Form A.

DEFINITIONS

In answering the following questions, please use these definitions:

"Ability to practice medicine" - This term includes:

1. The cognitive capacity to make and exercise reasoned medical judgments, and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks and procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" - Includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, hepatitis, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Currently" - This term means recently enough to have a real or perceived impact on one's functioning as a Physician Assistant licensee.

"Chemical substances" - This term is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Controlled substances" - This term means those drugs listed on Schedules I through V of Section 202 of the Controlled Substances Act (21 USC § 812).

"Illegal use of controlled substances" - This term means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act, as periodically updated by the Food and Drug Administration. This term does not include the use of a drug taken under the supervision of a licensed health care professional or other uses authorized by the Controlled Substances Act or other provisions of federal law.

40. Do you have a medical condition that potentially or in any way impairs or limits your ability to practice medicine in your field of practice with reasonable skill and safety?

_____ Yes _____ No

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your medical condition is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

41. Are you currently engaged in the use of alcohol or other chemical substances that potentially or in any way impairs your ability to practice medicine in your field of practice with reasonable skill and safety?

_____ Yes _____ No

In explaining a "Yes" answer on Form A, please provide reasonable assurances that your use is reduced or ameliorated because, for example, you have received or do receive ongoing treatment (with or without medication) or have participated or do participate in a monitoring program.

42. Are you currently engaged in the illegal use of controlled substances?

_____ Yes _____ No

In explaining a "Yes" answer on Form A, please provide reasonable assurances that such use is not a real and ongoing problem in your practice of medicine.

IMPORTANT

Since 1999, part of each physician license fee has been used to create and maintain the **Vermont Practitioners Health Program**, a **confidential** program for the identification, treatment and rehabilitation of practitioners affected by the disease of substance abuse. If you wish further information about this program, a service of the Vermont Medical Society, call 802-223-0400 (a confidential line).

Part III - Statutory Profile Questions

Vermont law, 26 VSA § 1368, creates a data repository within the Department of Health. Under this law, the Department must collect certain information to create individual profiles on all health care professionals licensed, certified, or registered by the Department pursuant to Title 26 of the VSA. Please try to answer the following questions as best you can. You will receive a copy of your profile prior to its initial release to the public and each time the profile is modified or amended. You will be given a reasonable time to correct factual inaccuracies that appear in such profile. As noted below, certain questions do not need to be answered.

It is very important for us to receive copies of court papers, licensing and certification authority decisions, and other documents relevant to the questions below in order to have a true and accurate description of the actions taken.

43. **Criminal Convictions** [See 26 VSA § 1368(a)(1)]

Please provide a description of all crimes (felonies and misdemeanors; this includes DUI but not speeding or parking tickets) of which you have been convicted. For purposes of this question, "convicted" means that you pleaded guilty or that you were found or adjudged guilty by a court of competent jurisdiction. **Please provide copies of papers fully documenting the convictions.**

(Conviction Date)	(Court)	(City/State)	(Crime)

(Conviction Date) (Court) (City/State) (Crime)

(Conviction Date) (Court) (City/State) (Crime)

44. **Nolo Contendere/Matters Continued** [See 26 VSA § 1368(a)(2)]

Please provide a description of all charges to which you pleaded "nolo contendere" ("I will not contest it") or where sufficient facts of guilt were found and the matter was continued without a finding by a court of competent jurisdiction. **Please provide copies of papers fully documenting these matters.**

(Conviction Date) (Court) (City/State) (Charge)

(Conviction Date) (Court) (City/State) (Charge)

(Conviction Date) (Court) (City/State) (Charge)

45. **Vermont Board of Medical Practice Matters** [See 26 VSA § 1368(a)(3)]

Please provide a description of all formal charges served, findings, conclusions, and orders of the Board of Medical Practice (including stipulations), and final disposition of such matters by the courts, if appealed.

(Date) (Final Disposition - Summary)

46. **Licensing or Certification Authority Matters in Other States** [See 26 VSA § 1368(a)(4)]

Please provide a description of all formal charges served by licensing or certification authorities of other states, the findings, conclusions, and orders of such authorities, and final disposition of such matters by the courts, if appealed, in those states. **Please provide copies of papers fully documenting these matters.**

(Date of Final Disposition) (Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

(Date of Final Disposition) (Licensing or Certification Authority) (Court) (City/State) (Nature of Charge)

47. **Restriction of Hospital Privileges** [See 26 VSA § 1368(a)(5)]

A. **Revocation/Involuntary Restrictions**

Please provide a description of any revocation or involuntary restriction of your hospital privileges that were related to competence or character and were issued by the hospital's governing body or any other official of the hospital after procedural due process (opportunity for hearing) was afforded to you. **Please provide copies of papers fully documenting these matters.**

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

(Date) (Hospital) (State) (Nature of Restriction) (Reason for Restriction)

B. Other Restrictions

Please provide a description of all resignations from, or non-renewal of, medical staff membership or the restriction of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to competence or character in that hospital. **Please provide copies of papers fully documenting these matters.**

(Date) (Hospital) (State)

(Nature of Action) (Action)

(Reason for Action) ☐ In lieu ☐ In settlement

48. Medical Malpractice Court Judgments/Settlements [See 26 VSA § 1368(a)(6A)]

A. Judgments

Please provide a description of all medical malpractice court judgments against you and all medical malpractice arbitration awards against you in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

☐ Judgement ☐ Arbitration

(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

☐ Judgement ☐ Arbitration

(Date) (Court) (State) (Nature of Case) (Amount Assessed Against You)

B. Settlements

Please provide a description of all settlements of medical malpractice claims against you in which a payment was awarded to a complaining party. **Please provide copies of papers fully documenting these matters.**

(Date) (Court) (State) (Amount of Settlement Against You)

(Date) (Court) (State) (Amount of Settlement Against You)

49. Years of Practice [See 26 VSA § 1368(a)(10)]

What month and year did you start practicing as a Physician Assistant?

50. **Hospital Privileges** [See 26 VSA § 1368(a)(11)]

List all hospitals where you currently have hospital staff privileges:

(Name)	(City)	(State)	(Year Started)
(Name)	(City)	(State)	(Year Started)
(Name)	(City)	(State)	(Year Started)

51. **Appointments/Teaching** [See 26 VSA § 1368(a)(12)]

Note: Answering #51 is optional. By answering, you are granting permission to have this information posted on the web. (This form follows the statutory wording. Since most appointments are teaching appointments, these questions may overlap.)

A. Appointments

Please provide information about your appointments to medical school or professional school faculties.

(School)	(City)	(State)	(Nature of Appointment)	From (year)	To (year)
(School)	(City)	(State)	(Nature of Appointment)	From (year)	To (year)

B. Teaching

Please provide information regarding your responsibility for teaching graduate medical education within the past 10 years.

(School/Institution)	(City)	(State)	(Nature of Teaching)	From (year)	To (year)
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52. **Publications** [See 26 VSA § 1368(a)(13)]

Note: Answering #52 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your publications in peer-reviewed medical literature within the past 10 years.

(Title)	(Publication)	(Year)
(Title)	(Publication)	(Year)

53. **Activities** [See 26 VSA § 1368(a)(14)]

Note: Answering #53 is optional. By answering, you are granting permission to have this information posted on the web.

Please provide information regarding your professional or community service activities and awards.

(Activities or Awards)

Part IV – Photograph and Signature

PROVIDE A PHOTOGRAPH: Attach a photograph below, taken within the last 60 days (head and shoulders). Proofs are not acceptable. Sign the front of the photograph. **Please do not use staples.**

Reminder - You must also complete the enclosed Applicant's Statement Regarding Child Support, Taxes, Unemployment Compensation Contributions.

I hereby affirm that the information provided above is true and accurate, and that I have answered the questions to the best of my knowledge and ability.

Date: _____

Applicant's Signature

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

REVOCATION OF CONSENT FORM

If at any time a prescriber wishes to revoke his or her consent to use of prescriber identifiable drug information, the revocation must occur using this form.

I _____ (**print name**) hereby **revoke** my consent to the use of regulated records which include prescription information containing my prescriber-identifiable data for the purpose of marketing or promoting a prescription drug.

Signature

Date

Name (printed or typed)

License type (profession)

Vermont License Number

Mailing Address

City, State, Zip

Please mail your completed form to:

Board of Medical Practice
Vermont Department of Health
PO Box 70
Burlington, VT 05402-0070

VERMONT'S PRESCRIPTION CONFIDENTIALITY LAW
Prescriber Data-Sharing Program

CONSENT FORM

Under Vermont's Act 80, a law passed in 2007, pharmaceutical companies may not use information that identifies prescribers in prescription drug records for marketing or promoting prescription drugs unless the prescriber consents. The text of the law, which took effect July 1, 2009, is found at 18 V.S.A. § 4631. The Vermont Attorney General has links to the statute and further information about the implementation of this law on the website. Go to <http://www.atg.state.vt.us/> and follow the link for Prescribed Products and then look for information on Prescription Confidentiality.

If you wish, you may permit your identifying information in drug prescription records to be used for marketing and promoting of prescription drugs. The only way to grant permission is by giving your consent in the manner described below. If you do not consent, your identifying information from prescription drug records cannot be used for marketing or promoting prescription drugs.

The list of everyone who has a current consent on file with their licensing board, as well as consent and revocation forms are available online at: http://healthvermont.gov/hc/med_board/bmp.aspx. You may check this site at any time to confirm your status. If you consent, your consent is effective until you revoke your consent. **If you wish to make a change, you may download consent and revocation forms at the web address above. If you do not have web access, you may contact your licensing board for assistance.**

How to consent: If you want to consent to the use of your information for marketing and promoting prescription drugs, sign your name, complete the form, and return it as part of your license application or license renewal. If you consent, your name will be included on the list of Vermont prescribers who have consented, and your information may be used for marketing and promoting prescription drugs. You may also complete this form at any time and mail it to your licensing board.

If you do not consent: If you do not wish your identifying information in prescription drug records to be used for marketing or promoting prescription drugs, you need do nothing.

If you choose not to consent, please leave this form blank.

To consent, sign, date, and fill out the form below. Return the completed form with your license application or license renewal or mail the form to **Board of Medical Practice, PO Box 70, Burlington, VT 05402-0070.**

I consent:

Signature Date

Name (printed or typed)

License type (profession) Vermont License Number

Mailing Address

City, State, Zip

FORM B

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

**FORM B: 1) AUTHORIZATION FOR RELEASE OF RECORDS AND INFORMATION AND 2)
AUTHORIZATION TO COMMUNICATE WITH FUTURE EMPLOYERS REGARDING THE
STATUS IF YOUR APPLICATION**

TO WHOM IT MAY CONCERN:

I, _____ HEREBY AUTHORIZE YOU to furnish to
(Name of Applicant)

the Vermont Board of Medical Practice or its designated representative, all materials and information within your possession or control relating to me, of whatever kind and wherever located and including, but not limited to, my professional experience and qualifications, my licensing history, my practice, and any other material or information, including investigative files, which, in the sole discretion of the Vermont Board of Medical Practice, may be useful to said Board in its review of my licensing status.

Only in regard to this specific authorization for disclosure to the Vermont Board of Medical Practice and for no other purpose, I expressly WAIVE confidentiality and any privileges or immunities accorded this information by State or Federal Law, and I hold you harmless from disclosure of same to the Vermont Board of Medical Practice.

YOU ARE ALSO AUTHORIZED to report information, either orally or in writing, directly to the Vermont Board of Medical Practice or its designated representative on a continuing basis until this authorization is revoked, by me, in writing.

A CONFORMED PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL SERVE IN ITS STEAD.

2) I further authorize the Vermont Board of Medical Practice to communicate with future employers and/or locum tenens companies regarding the status of my application.

Signature: _____

Date: _____

Print or Type Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: (_____) _____

Subscribed and sworn to before me, this _____ day of _____

Notary Public

A CONFORMED COPY, ATTEST _____
Notary Public

**RETURN ORIGINAL TO THE BOARD WITH YOUR APPLICATION
SEND COPIES WITH THE REFERENCE FORMS**

Vermont Department of Health - Board of Medical Practice

APPLICANT'S STATEMENT REGARDING CHILD SUPPORT, TAXES,
UNEMPLOYMENT COMPENSATION CONTRIBUTIONS

You must answer questions 1, 2, and 3.

Regarding Child Support

Title 15 § 795 requires that: A professional license or other authority to conduct a trade or business may not be issued or renewed unless the person certifies that he or she is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order as of the date the application is filed. "Good standing" means that less than one-twelfth of the annual support obligation is overdue; or liability for any support payable is being contested in a judicial or quasi-judicial proceeding; or he or she is in compliance with a repayment plan approved by the office of child support or agreed to by the parties; or the licensing authority determines that immediate payment of support would impose an unreasonable hardship. (15 V.S.A. § 795)

1. You must check one of the two statements below regarding child support regardless whether or not you have children:
- ☐ I hereby certify that, as of the date of this application: (a) I am not subject to any support order or (b) I am subject to a support order and I am in good standing with respect to it, or (c) I am subject to a support order and I am in full compliance with a plan to pay any and all child support due under that order.
- or
- ☐ I hereby certify that I am NOT in good standing with respect to child support dues as of the date of this application and I hereby request that the licensing authority determine that immediate payment of child support would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Taxes

Title 32 § 3113 requires that: A professional license or other authority to conduct a trade or business shall not be issued or renewed unless the person certifies that he or she is in good standing with the Department of Taxes. "Good standing" means that no taxes are due and payable and all returns have been filed, the tax liability is on appeal, the taxpayer is in compliance with a payment plan approved by the Commissioner of Taxes, or the licensing authority determines that immediate payment of taxes would impose an unreasonable hardship. (32 V.S.A. § 3113)

2. You must check one of the two statements below regarding taxes:
- ☐ I hereby certify, under the pains and penalties or perjury, that I am in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont as of the date of this application. (The maximum penalty for perjury is fifteen years in prison, a \$10,000.00 fine or both).
- or
- ☐ I hereby certify that I am NOT in good standing with respect to taxes due to the State of Vermont as of the date of this application and I hereby request that the licensing authority determine that immediate payment of taxes would impose an unreasonable hardship. Please forward an "Application for Hardship".

Regarding Unemployment Compensation Contributions

Title 21 § 1378 requires that: No agency of the state shall grant, issue or renew any license or other authority to conduct a trade or business (including a license to practice a profession) to, or enter into, extend or renew any contract for the provision of goods, services, or real estate space with any employing unit unless such employing unit shall first sign a written declaration, under the pains and penalties of perjury, that the employing unit is in good standing with respect to or in full compliance with a plan to pay any and all contributions or payments in lieu of contributions due as of the date such declaration is made. For the purposes of this section, a person is in good standing with respect to any and all contributions or payments in lieu of contributions payable if: (1) no contributions or payments in lieu of contributions are due and payable; (2) the liability for any contributions or payments in lieu of contributions due and payable is on appeal; (3) the employing unit is in compliance with a payment plan approved by the Commissioner; or (4) in the case of a licensee, the agency finds that requiring immediate payment of contributions or payments in lieu of contributions due and payable would impose an unreasonable hardship.

3. You must check one of the three statements below regarding unemployment contributions or payments in lieu of unemployment contributions:
- ☐ I hereby certify, under the pains and penalties of perjury, that I am in good standing with respect to or in full compliance with a payment plan approved by the Commissioner of Employment and Training to pay any and all unemployment contributions or payments in lieu of unemployment contributions to the Vermont Department of Employment and Training due as of the date of this application. (The maximum penalty for perjury is 15 years in prison, a \$10,000.00 fine or both.)
- or
- ☐ I hereby certify that I am NOT in good standing with respect to unemployment contributions or payments in lieu of unemployment contributions due to the Vermont Department of Employment and Training as of the date of this application and I hereby request that the licensing authority determine that requiring immediate payment of unemployment contributions or payments in lieu of unemployment contributions would impose an unreasonable hardship. Please forward an Application for Hardship.
- or
- ☐ I hereby certify that 21 V.S.A. § 1378 is not applicable to me because I am not now, nor have I ever been, an employer.

Social Security #* ____/____/____ Date of Birth ____/____/____

* The disclosure of your social security number is mandatory, it is solicited by the authority granted by 42 U.S.C. § 405 (c)(2)(C), and will be used by the Department of Taxes and the Department of Employment and Training in the administration of Vermont tax laws, to identify individuals affected by such laws, and by the Office of Child Support.

STATEMENT OF APPLICANT

I certify that the information stated by me in this application is true and accurate to the best of my knowledge and that I understand providing false information or omission of information is unlawful and may jeopardize my license/certification/registration status.

Signature of Applicant _____ Date _____

State of Vermont
Department of Health
Board of Medical Practice

Statement of Good Standing

**Regarding Any Unpaid Judgment Issued by the Judicial Bureau or
District Court for Fines or Penalties for a Violation or Criminal Offense**

I hereby state that I am in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense.

I understand that a license may not be issued or renewed without such a statement.

I further understand that, for the purposes of this section, a person is in good standing with respect to any unpaid judgment issued by the judicial bureau or district court for fines or penalties for a violation or criminal offense if:

- (1) 60 days or fewer have elapsed since the date a judgment was issued; or
- (2) the person is in compliance with a repayment plan approved by the judiciary.

Date

Signature

**-Vermont Department of Health - Board of Medical Practice
Form A**

PLEASE PROVIDE EXPLANATIONS TO "YES" ANSWERS ON THIS FORM

Withdrawal or denial of license or certificate (Questions 27 and 28) - Attach documents

State _____ Year _____
Circumstances under which license or certificate was withdrawn, denied, revoked, not renewed, or otherwise terminated _____

**Voluntarily surrendered or resigned a license or certificate to practice medicine or any healing art
(Question 29) - Attach documents**

State _____ Year _____
Circumstances _____

Disciplinary charges or action (Question 30) - Attach documents

Name of organization involved _____ Date _____
Duration _____

Action taken (circle all that apply)

- | | |
|---------------------------------------------|-------------------------------------------|
| 01 Revocation of right or privilege | 12 Leave of absence |
| 02 Suspension of right or privilege | 13 Withdrawal of an application |
| 03 Censure | 14 Termination or non-renewal of contract |
| 04 Written reprimand or admonition | 15 Medical Records Suspension |
| 05 Restriction of right or privilege | 16 Probation |
| 06 Non-renewal of right or privilege | 17 Assurance of Discontinuance |
| 07 Fine | 18 Consent Agreement |
| 08 Required performance of public service | 19 Letter of Agreement |
| 09 Education/Training/Counseling/Monitoring | 20 Expulsion from Membership |
| 10 Denial of rights or privilege | 21 Reprimand |
| 11 Resignation | 22 Other (specify) _____ |

Circumstances _____

Denial of examination privileges (Question 31) - Attach documents

State _____ Year _____
Circumstances under which examination privileges denied _____

Training program(s) not completed - discontinued education, training, practice (Questions 32 and 33) - Attach documents

Training program(s) _____

Location of programs _____ Year _____

Circumstances _____

Affecting health care institution staff privileges, employment or appointment (Question 34) - Attach documents

Institution involved _____

Location _____ Year _____

Circumstances _____

Privilege to prescribe controlled substances (Question 35) - Attach documents

Name of organization involved _____

Type of restriction _____ Date _____

Circumstances of restriction

Criminal investigation - proceeding (Questions 36 and 39) - Attach documents

Court _____

City and state _____

Charge _____

Description _____

Status _____

Conviction? ____ Yes ____ No Date _____

Plea? ____ Yes ____ No Date _____

(Question 37) Internet prescribing

Please provide a general description of your practice of internet prescribing

Investigation by other licensing or certification board - proceeding (Question 38) - Attach documents

Date _____

Licensing or certification board _____

State _____

Description _____

Status _____

Medical condition, treatment, use of chemical or illegal substances (Questions 40-42)

Treating organization _____

Address _____ Telephone _____

Type of diagnosis, condition or treatment - field of practice - use of chemical substances

Dates of illness of dependency _____ to _____

Dates of treatment _____ to _____

Name of rehabilitation/professional assistance or monitoring program _____

Address _____ Telephone _____

Contact person at Program _____

(Question 48) Medical Malpractice Claim

Please provide the following information regarding each instance of alleged malpractice. This section should be photo copied and filled out separately for each claim. Additional sheets may be obtained/used if necessary.

Insurer _____

Claimant name _____

Description of alleged claim (allegations only): This does not constitute an admission of fault or liability.

Please indicate:

1. Patient's condition at point of your involvement;
2. Patient's condition at end of treatment;
3. The nature and extent of your involvement with the patient;
4. Your degree of responsibility for the course of treatment in leading to the claim; and
5. Narrative of event.

If the incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

Your role (circle one):

- | | |
|---------------------------|-------------------------------------|
| 01 Anesthesiologist | 11 PGY 4 |
| 02 Primary Care Physician | 12 PGY 5 |
| 03 Referring Physician | 13 PGY 6 |
| 04 Attending Physician | 14 PGY 7 |
| 05 Consultant Specialist | 15 Workmen's Compensation Evaluator |
| 06 Surgeon | 16 Court Psychiatrist |
| 07 Fellow | 17 On-Call Physician |
| 08 PGY 1 | 18 Group Practitioner/Partner |
| 09 PGY 2 | 19 Other: Specify _____ |
| 10 PGY 3 | 20 Unknown |

Your Legal Representative in this matter (include name, address and telephone number)

Name _____

Firm _____

Address _____

City, State, Zip _____

Phone _____

Indicate Decision, Appeal, Settlement, Dismissal:

Vermont Department of Health - Board of Medical Practice
Form A

If a Court or Arbitration Panel heard your case, indicate the following:

Court _____

Court's location _____

Docket number _____

Date the action was filed _____

Decision determined by (check one): _____ Judge _____ Jury _____ Arbitration Panel

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date appeal filed (month, day, year)

____/____/____

Date appeal decided: (month, day, year) ____/____/____

If your case was settled, indicate the following:

Settlement amount paid on your behalf: _____

Total settlement amount: _____

Date of settlement: (month, day, year) ____/____/____

____ Case dismissed against you ____ Against all defendants

Important: In addition to the above information, please attach a copy of the complaint and final judgment, settlement and release, or other final disposition of the claim. This information can be obtained from your legal representative.

Additional information, if any:

EMPLOYMENT CONTRACT

I, _____, an applicant for
(Applicant's Name)

Certification as a Physician Assistant, am employed by

(Employer's Name)

for the period beginning _____
(Month/Day/Year)

Termination of my contract will cause my Certification to become null and void.

Signature of Physician Assistant (Date)

Signature of Supervising Physician (Date)

Print Name of Physician _____

NOTE: A contract from each separate employer is required.

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

VERIFICATION OF PHYSICIAN ASSISTANT LICENSURE OR CERTIFICATION

This section must be completed by the regulatory authority in the states in which **you now hold or have ever held** a license or certification to practice as a physician's assistant.

I, _____ Secretary of the _____

State Board of _____, certify that

_____ was granted Certificate Number _____

to practice as a physician's assistant in the State of _____

on the _____ day of _____ 19 _____

and that said certificate has never been revoked, suspended or conditioned in any way, or the licensee has never been disciplined by the Board in any way.

NOTE: If licensed by written examination the secretary should further certify:

I further certify that the aforesaid _____ in his/her written

Examination before this Board, obtained a general average of _____ percent in the

Following branches:

(The subjects of the examination and rating of each must be stated in full.)

(AFFIX SEAL) _____
(Secretary/Director)

(Date)

PRIMARY SUPERVISING PHYSICIAN APPLICATION

Note: A PA who prescribes controlled drugs must obtain an ID number from DEA. PA's DEA Number

SECONDARY SUPERVISING PHYSICIAN APPLICATION

(Signature of Secondary Supervising Physician)

Vermont Department of Health - Board of Medical Practice

SPECIALTY CODES LIST
(primary care specialties in boldface)

0101 Allergy and Immunology	0712 Medical Oncology	1503 Clinical Pathology
0102 Clinical & Laboratory Immunology	0713 Nephrology	1504 Blood
	0714 Pulmonary Disease	Banking/Transfusion Medicine
0201 Anesthesiology	0715 Rheumatology	1505 Chemical Pathology
0202 Critical Care Medicine	0716 Sports Medicine	1506 Cytopathology
0203 Pain Management		1507 Dermatopathology
	0801 Medical Genetics	1508 Forensic Pathology
0301 Colon & Rectal Surgery	0802 Clinical Biochemical Genetics	1509 Hematology
	0803 Clinical Biochemical/Molecular Genetics	1510 Immunopathology
0401 Dermatology	0804 Clinical Cytogenetics	1511 Medical Microbiology
0402 Dermatopathology	0805 Clinical Genetics (Md)	1512 Neuropathology
0403 Clinical & Laboratory Dermatology	0806 Clinical Molecular Genetics	1513 Pediatric Pathology
0404 Dermatological Immunology		
		1601 Pediatrics
0501 Emergency Medicine	0901 Neurological Surgery	1602 Adolescent Medicine
0502 Medical Toxicology	0902 Critical Care Medicine	1603 Clinical & Laboratory Immunology
0503 Pediatric Emergency Medicine	1001 Nuclear Medicine	1604 Medical Toxicology
0504 Sports Medicine		1605 Neonatal-Perinatal Medicine
	1101 Obstetrics & Gynecology	1606 Pediatric Cardiology
0601 Family Practice	1102 Critical Care Medicine	1607 Pediatric Critical Care Medicine
0602 Geriatric Medicine	1103 Gynecologic Oncology	1608 Pediatric Emergency Medicine
0603 Sports Medicine	1104 Maternal & Fetal Medicine	1609 Pediatric Endocrinology
	1105 Reproductive Endocrinology	1610 Pediatric Gastroenterology
0701 Internal Medicine	1201 Ophthalmology	1611 Pediatric Hematology-Oncology
0702 Adolescent Medicine	1301 Orthopaedic Surgery	1612 Pediatric Infectious Disease
0703 Cardiac Electrophysiology	1302 Hand Surgery	1613 Pediatric Nephrology
0704 Cardiovascular Disease		1614 Pediatric Pulmonology
0705 Critical Care Medicine	1401 Otolaryngology	1615 Pediatric Rheumatology
0706 Clinical & Laboratory Immunology	1402 Otology/Neurotology	1616 Pediatric Sports Medicine
0707 Endocrinology Diabetes & Metabolism	1403 Pediatric Otolaryngology	1617 Children With Special Health Needs
0708 Gastroenterology	1501 Anatomic & Clinical Pathology	
0709 Geriatric Medicine	1502 Anatomic Pathology	
0710 Hematology		
0711 Infectious Disease		

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401
(802) 657- 4220

CERTIFICATE OF PHYSICIAN ASSISTANT EDUCATION

I hereby certify that, _____ was admitted to the
(Name)

_____ Physician Assistant

Program in _____ on _____
(City and State) (Date)

and completed all requirements for graduation on _____
(Date)

A _____ was granted on _____
(Specify certificate/diploma/degree) (Date)

Is this program CAHEA or successor agency approved? _____ Yes _____ No

(AFFIX SEAL)

Date: _____

Signed: _____
(Authorized Officer of the School)

TO PROGRAM: Return to above address

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

LIST OF TWO REFERENCES

The Board rules require that references be from allopathic or osteopathic physicians with whom the applicant has worked recently, including one from the most recent primary supervisor. If the applicant has recently graduated from a Board-approved physician assistant program, one must be from the Director of the program. If the applicant has recently completed a Board-approved apprenticeship program, one must be from the primary training physician.

Detach the attached Reference Forms and send to the individuals designated below ALONG WITH A COPY OF THE SIGNED FORM B RELEASE. Return this sheet to the Board with your application. Individuals completing the reference forms must return the forms directly to the Board.

Names, addresses and telephone numbers of two references:

1) Reference #1 – Name of a Physician: _____

Address: _____

City, State, Zip Code: _____

Telephone: (_____) _____

How long has this individual known you? _____

2) Reference #2 – Name of a Physician: _____

Address: _____

City, State, Zip Code: _____

Telephone: (_____) _____

How long has this individual known you? _____

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

Name of applicant: _____

The physician assistant named above has applied to the Vermont Board of Medical Practice for a certification to practice as a physician assistant in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Name _____ was at _____

From _____ to _____. During that time, he/she

Was (List status in the institution): _____

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

The basic medical knowledge to be expected in a PA:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Professional judgement:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Sense of responsibility:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Moral character/ethical conduct:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Competence and skills in the tasks delegated:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Cooperativeness ability to work with others:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Willingness to accept directions and limitations in role:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
History & physical exam:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Record keeping:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
P.A.-Patient relationship:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Track record in adhering to scope of practice:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Ability to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
(802) 657- 4220

REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY
PAGE TWO OF TWO

Name of applicant: _____

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? ☐ Yes ☐ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice as a physician's assistant? ☐ Yes ☐ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? ☐ Yes ☐ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? ☐ Yes ☐ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? ☐ Yes ☐ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? ☐ Yes ☐ No

Do you know of any confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ☐ Yes ☐ No

Do you know of a failure of the applicant to complete a training program(s)? ☐ Yes ☐ No

Does the applicant call upon consults when needed? ☐ Yes ☐ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any applicant are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

- ☐ Close personal observation
☐ General impression
☐ A composite of previous evaluations
☐ Other – Specify: _____

I further certify that at the time of completion of the above training, or during my association with the physician assistant, he/she was competent to practice as a physician assistant and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
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Name of applicant: _____

The physician assistant named above has applied to the Vermont Board of Medical Practice for a certification to practice as a physician assistant in Vermont. The applicant has listed your name as one who has requisite knowledge through recent observation of the applicant's current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following reference form. Thank you for your cooperation.

Please complete all parts of this form. If more room is needed, please attach additional information.

Name _____ was at _____

From _____ to _____. During that time, he/she

Was (List status in the institution): _____

IMPORTANT NOTE: If you rate the applicant "poor" or "fair" in a particular category, please elaborate on this aspect of the reference in as much detail as possible.

The basic medical knowledge to be expected in a PA:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Professional judgement:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Sense of responsibility:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Moral character/ethical conduct:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Competence and skills in the tasks delegated:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Cooperativeness ability to work with others:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Willingness to accept directions and limitations in role:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
History & physical exam:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Record keeping:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
P.A.-Patient relationship:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Track record in adhering to scope of practice:	_____ Poor	_____ Fair	_____ Average	_____ Above Average
Ability to communicate in reading, writing and speaking the English language:	_____ Poor	_____ Fair	_____ Average	_____ Above Average

STATE OF VERMONT – BOARD OF MEDICAL PRACTICE
108 CHERRY STREET
BURLINGTON, VERMONT 05401-0070
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REFERENCE FORM TO BE COMPLETED BY PHYSICIAN WORKED WITH MOST RECENTLY
PAGE TWO OF TWO

Name of applicant: _____

To the best of your knowledge, does/did the applicant carry out the duties and responsibilities of the position at your institution in a satisfactory manner? ☐ Yes ☐ No

Do you know of any emotional disturbance, mental illness, organic illness, alcohol or drug problem, which might impair the applicant's ability to practice as a physician's assistant? ☐ Yes ☐ No

Do you know of any pending professional misconduct proceedings or medical malpractice claims? ☐ Yes ☐ No

Do you know if the applicant has been a defendant in any criminal proceeding other than minor traffic offenses? ☐ Yes ☐ No

Do you know of any suspension, restriction or termination of training or professional privileges for reasons related to mental or physical impairment, incompetence, misconduct or malpractice? ☐ Yes ☐ No

Do you know of any resignation or withdrawal from training or of professional privileges to avoid imposition of disciplinary measures? ☐ Yes ☐ No

Do you know of any confirmed quality concern (quality of hospital care provided to Medicare patients) by the Peer Review Organization (PRO) in Vermont or elsewhere? ☐ Yes ☐ No

Do you know of a failure of the applicant to complete a training program(s)? ☐ Yes ☐ No

Does the applicant call upon consults when needed? ☐ Yes ☐ No

In addition to the information provided on the previous page, please use the space below and the reverse side for elaboration on the above and any additional information you have available to aid the Board in evaluating this applicant. Of particular value to us in evaluating any applicant are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

The above report is based on:

☐ Close personal observation

☐ General impression

☐ A composite of previous evaluations

☐ Other – Specify: _____

I further certify that at the time of completion of the above training, or during my association with the physician assistant, he/she was competent to practice as a physician assistant and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Vermont.

Signed: _____ Date: _____

Print or Type Name and Title: _____

3.1.11 AUTHORITY TO PRESCRIBE DRUGS

The certified physician's assistant may prescribe only those drugs utilized by the primary supervising physician and permitted by the scope of practice submitted to and approved by the Board.

The drug order shall be signed, "(physician assistant's name) for (physician's name)".

Upon a pharmacist's request, the Board shall furnish a copy of the Board approved scope of practice and a signature sample of the physician's assistant.

3.1.12 PRIMARY SUPERVISING PHYSICIAN

The supervising physician shall:

1. be qualified to practice medicine in the field(s) of medicine in which he or she actively practices;
2. supervise physician assistants only in the field(s) of medicine in which he or she actively practices;
3. submit his or her usual scope of practice as defined in 3.1.1, 10 a).
4. outline in detail how he or she will be available for consultation and review of work performed by the physician's assistant;
5. supervise no more physician assistants concurrently than have been approved by the Board after review of the system of care delivery;
6. furnish copies of the physician assistant's scope of practice to any medical facilities with which the physician's assistant is affiliated or employed;
7. conduct and document regular chart reviews, such as chart audits, and retrospective patient care audits, or review and countersign PA notes;
8. immediately notify the Board in writing of dissolution of the physician assistant's employment contract and the reason(s) for dissolution. Similar notification is required if the scope of practice changes, the employer(s) change, or there is a change in the primary or secondary supervising physician(s). Board approval must be received, otherwise the PA's certificate becomes void. Documents already on file with the Board need not be resubmitted.
9. sign a statement certifying that the primary supervising physician has read the statutes and Board rules governing physician assistants.

3.1.13 SECONDARY SUPERVISING PHYSICIAN

The secondary supervising physician shall:

1. be qualified to practice in the field(s) of medicine in which the physician assistant is practicing;
2. supervise physician assistants only in the field(s) of medicine in which he or she actively practices;
3. be responsible for the physician assistant's medical acts only when consulted by the physician assistant.
4. be available for consultation as secondary supervising physician;
5. have read and signed the scope of practice submitted to and approved by the Board;
6. supervise no more physician assistants concurrently than have been approved by the Board after review of the system of care delivery;
7. immediately notify the Board of dissolution of secondary supervision and reasons for dissolution of the physician assistant employment contract. The notification shall include the reasons for ending the employment relationship if any of the grounds of unprofessional conduct as described in 26 V.S.A. Section 1736 has occurred;
8. sign a statement certifying that the secondary supervising physician has read the statutes and Board rules governing physician assistants.

VERMONT BOARD OF MEDICAL PRACTICE PHYSICIAN ASSISTANT SCOPE OF PRACTICE

"Scope of practice" means a written document detailing those areas of medical practice including duties and medical acts, delegated to the physician assistant by the supervising physician for which the licensee is qualified by education, training and experience. At no time shall the scope of practice of the physician assistant exceed the normal scope of either the primary or secondary supervising physician(s) practice.

Physician assistants practice medicine with physician supervision. Physician assistants may perform those duties and responsibilities, including the prescribing and dispensing of drugs and medical devices, that are delegated by their supervising physician(s).

Physician assistants shall be considered the agents of their supervising physicians in the performance of all practice-related activities, including but not limited to, the ordering of diagnostic, therapeutic and other medical services.

It is the obligation of each team of physician(s) and the physician assistant(s) to insure that the written scope of practice submitted to the Board for approval clearly delineates the role of the physician assistant in the medical practice of the supervising physician. This should cover at least the following categories:

a) Narrative: A brief description of the practice setting, the types of patients and patient encounters common to this practice and a general overview of the role of the physician assistant in that practice.

b) Supervision: A detailed explanation of the mechanisms for on-site and off-site physician supervision and communication, back-up and secondary supervising physician utilization. Included here should be a description of the method of transport and back-up procedures for immediate care and transport of patients who are in need of emergency care when the supervising physician is not on premises. This explanation should include issues such as, ongoing review of the physician assistant's activities, retrospective chart review, co-signing of patient charts, and utilization of the services of non-supervising physicians and consultants.

c) Sites of Practice: A description of any and all practice sites (i.e. office, clinic, hospital outpatient, hospital inpatient, industrial sites, schools, etc.). For each site, a description of the PA's activities.

d) Tasks/Duties: A list of the PA's tasks and duties in the supervising physician's scope of practice.

This list should express a sense of involvement in the level of medical care in that practice. The supervising physician may only delegate those tasks for which the physician assistant is qualified by education, training and experience to perform. Notwithstanding the above, the physician assistant should initiate emergency care when required while accessing back-up assistance. At no time should a particular task assigned to the-PA fall outside of the scope of practice of the supervising physician.

e) An authorization to prescribe medications which includes the following statements:

1) The physician assistant named in this document will be authorized to prescribe medications in, accordance with the scope of practice submitted to and approved by the Vermont Board of Medical Practice.,

2) The physician assistant named in this document will be authorized to prescribe controlled drugs in accordance with the scope of practice submitted to and approved by the Vermont Board of Medical Practice. A physician assistant who prescribes controlled drugs must obtain an identification number from the federal Drug Enforcement Agency (DEA). The physician assistant DEA number is (insert DEA number).

NATIONAL PRACTITIONER DATA BANK
HEALTHCARE INTEGRITY and PROTECTION DATA BANK
PO Box 10832, Chantilly, Virginia 20153-0832
www.npdb-hipdb.com

On-line Self-Query Process

- Log-on to web site for NPDB as shown above

TO SUBMIT A QUERY:

- Select "Report to and Query the Data Banks"
- Click on "Perform a Self-Query"
- Select the type of self-query you wish to perform
Individual or organization
- Provide ALL required information
- Provide your credit card information (VISA, MasterCard, or Discover)
(Checks or cash not accepted)
- Once all information is complete, click CONTINUE. A formatted copy of the self-query is generated immediately with a Data Bank Control Number (DCN) listed at the top of the page. Print this formatted copy, and keep the DCN to monitor the processing status of your self-query. To print a query from the IQRS, you must have Adobe Acrobat Reader version 4.0 or higher installed on your computer.
- To complete the self-query process, you **must sign the formatted self-query application in the presence of a notary public** and mail it to the NPDB-HIPDB. Self-queries received without notarization or with an incomplete notarization are rejected. Notarized forms that are missing credit card information will be rejected.

Vermont Department of Health
Board of Medical Practice
108 Cherry Street PO Box 70
Burlington, VT 05401

NATIONAL PRACTITIONER DATA BANK SELF QUERY

Effective September 1, 1990, the Federal government opened the National Practitioner Data Bank. This data bank, mandated by Congress, tracks regulatory board disciplinary actions, certain actions resulting from peer review and malpractice payments.

You must self query this data bank on your own record as part of the application process for a Vermont medical license. Simply query the data bank using the attached form and when you receive the response, **SEND THE ORIGINAL, UNALTERED** response to the Board. You may keep a photocopy if you wish.

Before completing the data bank form, please contact the Data Bank Help Line for assistance: Help Line Toll Free Number: 1-800-767-6732.